AMENDED IN SENATE SEPTEMBER 2, 2003

AMENDED IN SENATE AUGUST 18, 2003

AMENDED IN SENATE JULY 15, 2003

AMENDED IN SENATE JUNE 30, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 1286

Introduced by Assembly Member Frommer
(Coauthors: Assembly Members Pavley and Wiggins)

February 21, 2003

~~An act to add Article 12 (commencing with Section 1399.820) to Chapter 2.2 of Division 2 of, and to repeal Sections 1373.65, 1373.95, and 1373.96 of, the Health and Safety Code, and to add Section 10133.561 to the~~ *An act to repeal and add Sections 1373.65, 1373.95, and 1373.96 of the Health and Safety Code, and to amend Section 10133.56 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1286, as amended, Frommer. Continuity of care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act's provisions a crime. ~~The act requires~~ *Existing law also provides for the regulation of health insurers by the Department of Insurance.*

Under existing law, a health care service plan providing coverage on a group basis~~,~~ *is required* to file with the department a written continuity of care policy for a new enrollee who is receiving services for an acute

condition from a nonparticipating provider. ~~Under the act,~~ *Existing law requires* a plan ~~is required~~ to provide 30 ~~days~~ *days'* notice of the termination of specified provider contracts to an enrollee receiving a course of treatment from the terminated provider. Under ~~the act~~ *existing law,* a plan ~~is also~~ *and a health insurer, as specified, are* required to arrange for the continuation of *covered* services by a terminated provider to an enrollee *or insured undergoing a course of treatment* for an acute condition, serious chronic condition, or pregnancy, as defined.

This bill would ~~repeal as of July 1, 2004, these continuity of care provisions. The bill would~~ require a health care service plan, *other than a specialized health care service plan offering mental health services on an employer-sponsored group basis,* to file with the department by March 31, 2004, a written continuity of care policy describing its procedures for the block transfer of enrollees from a terminated provider *group or hospital, as defined,* to a new provider *group or hospital,* including the notice it proposes to send affected enrollees *and its process to facilitate the completion of covered services for enrollees.* ~~The bill would make the policy's provisions, if approved by the department, effective July 1, 2004.~~

~~The~~

This bill would ~~impose other continuity of care provisions to become operative on July 1, 2004. The bill would~~ require that a health care service plan *submit a block transfer filing to the department at least 75 days prior to the termination of its contract with a provider group or a general acute care hospital and* provide 60 days' notice of the *contract's* termination ~~of a contract with any of its providers~~ to ~~those~~ enrollees assigned to the terminated provider. ~~The bill would also require the plan to provide transition of care, defined as the process of assigning enrollees to a new provider when the contract between their currently assigned provider and the plan is terminated, and to provide enrollees the option to elect maintenance of care and, if the enrollee has a specified condition, the option to elect completion of care. The bill would require a plan and provider to establish the reimbursement rate for maintenance of care and completion of care before entering into or amending a contract on or after July 1, 2004~~ *The bill would specify the requirements for an insurer to provide completion of covered services by a terminated provider and for a plan to provide those services either by a terminated provider or by a nonparticipating provider to a newly covered enrollee. The bill would also require a plan and a health insurer to provide completion of covered services for a surgery or procedure*

recommended and documented by a provider under specified circumstances.

The bill would require a health care service plan and a provider to include in any written, *printed,* or electronic communication to an enrollee a specific statement concerning continuity of care rights.

Because the bill would specify additional requirements under the Knox-Keene Health Care Service Plan Act of 1975, the violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would make the operation of its provisions contingent upon the enactment of SB 244.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. (a) It is the intent of the Legislature to clarify the rights of consumers when a disruption of the provider network of their health care service plan or health insurer occurs. During the past two years, over 2.3 million Californians have been affected by contract terminations that have resulted in the block transfer of large groups of enrollees and insureds from a terminated provider to a new provider.

(b) It is the further intent of the Legislature to provide consumers with expanded rights to ensure a smooth transition to a new provider and to complete a course of treatment with the same provider or to maintain the same provider under certain circumstances.

~~(c) The Legislature intends that the repeal by this act of Section 1373.95 of the Health and Safety Code shall in no way limit or otherwise curtail any of the existing provisions of that section as they apply to the continuity of care of mental health services.~~

SEC. 2. Section 1373.65 of the Health and Safety Code is repealed.

SEC. 3. *Section 1373.65 is added to the Health and Safety Code, to read:*

1373.65. (a) At least 75 days prior to the termination date of its contract with a provider group or a general acute care hospital, the health care service plan shall submit an enrollee block transfer filing to the department that includes the written notice the plan proposes to send to affected enrollees. The plan may not send this notice to enrollees until the department has reviewed and approved its content. If the department does not respond within seven days of the date of its receipt of the filing, the notice shall be deemed approved.

(b) At least 60 days prior to the termination date of a contract between a health care service plan and a provider group or a general acute care hospital, the plan shall send the written notice described in subdivision (a) by United States mail to enrollees who are assigned to the terminated provider group or hospital. A plan that is unable to comply with the timeframe because of exigent circumstances shall apply to the department for a waiver. The plan is excused from complying with this requirement only if its waiver application is granted by the department or the department does not respond within seven days of the date of its receipt of the waiver application. If the terminated provider is a hospital and the plan assigns enrollees to a provider group with exclusive admitting privileges to the hospital, the plan shall send the written notice to each enrollee who is a member of the provider group and who resides within a 15-mile radius of the terminated hospital. If the plan operates as a preferred provider organization or assigns members to a provider group with admitting privileges to hospitals in the same geographic area as the terminated hospital, the plan shall send the written notice to all enrollees who reside within a 15-mile radius of the terminated hospital.

(c) The health care service plan shall send enrollees of a preferred provider organization the written notice required by subdivision (b) only if the terminated provider is a general acute care hospital.

(d) If an individual provider terminates his or her contract or employment with a provider group that contracts with a health care service plan, the plan may require that the provider group send the notice required by subdivision (b).

(e) If, after sending the notice required by subdivision (b), a health care service plan reaches an agreement with a terminated provider to renew or enter into a new contract or to not terminate their contract, the plan shall offer each affected enrollee the option to return to that provider. If an affected enrollee does not exercise this option, the plan shall reassign the enrollee to another provider.

(f) A health care service plan and a provider shall include in all written, printed, or electronic communications sent to an enrollee that concern the contract termination or block transfer, the following statement in not less than eight-point type: "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.com."

(g) For purposes of this section, "provider group" means a medical group, independent practice association, or any other similar organization.

SEC. 4. Section 1373.95 of the Health and Safety Code is repealed.

~~SEC. 4.~~

SEC. 5. Section 1373.95 is added to the Health and Safety Code, to read:

1373.95. (a) (1) A health care service plan, other than a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall file a written continuity of care policy as a material modification with the department before March 31, 2004.

(2) A health care service plan shall include all of the following in its written continuity of care policy:

(A) A description of the plan's process for the block transfer of enrollees from a terminated provider group or hospital to a new provider group or hospital.

(B) A description of the manner in which the plan facilitates the completion of covered services pursuant to the provisions of Section 1373.96.

(C) A template of the notice the plan proposes to send to enrollees describing its policy and informing enrollees of their right to completion of covered services.

(D) A description of the plan's process to review an enrollee's request for the completion of covered services.

(E) A provision ensuring that reasonable consideration is given to the potential clinical effect on an enrollee's treatment caused by a change of provider.

(3) If approved by the department, the provisions of the written continuity of care policy shall replace all prior continuity of care policies. The plan shall file a revision of the policy with the department if it makes a material change to it.

(b) (1) The provisions of this subdivision apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(2) The plan shall file with the department a written policy describing the manner in which it facilitates the continuity of care for a new enrollee who has been receiving services from a nonparticipating mental health provider for an acute, serious, or chronic mental health condition when his or her employer changed health plans. The written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to a participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account on a case-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The policy shall ensure that reasonable consideration is given to the potential clinical effect of a change of provider on the enrollee's treatment for the condition. The policy shall describe the plan's process to review an enrollee's request to continue his or her course of treatment with a nonparticipating mental health provider. Nothing in this paragraph shall be construed to require the plan to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the plan may require the nonparticipating mental health provider,

as a condition of the right conferred under this section, to enter into its standard mental health provider contract.

(3) A plan may require a nonparticipating mental health provider whose services are continued pursuant to the written policy, to agree in writing to the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the plan determines that an enrollee's health care treatment should temporarily continue with his or her existing provider or nonparticipating mental health provider, the plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provisions of services by the existing provider or a nonparticipating mental health provider.

(4) The written policy shall not apply to an enrollee who is offered an out-of-network option or to an enrollee who had the option to continue with his or her previous specialized health care service plan that offers professional mental health services on an employer-sponsored group basis or mental health provider and instead voluntarily chose to change health plans.

(5) This subdivision shall not apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis if it includes out-of-network coverage that allows the enrollee to obtain services from his or her existing mental health provider or nonparticipating mental health provider.

(c) The health care service plan, including a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall provide to all new enrollees notice of its written continuity of care policy and information regarding the process for an enrollee to request a review under the policy and shall provide, upon request, a copy of the written policy to an enrollee.

(d) Nothing in this section shall require a health care service plan or a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

(e) The following definitions apply for the purposes of this section:

(1) "Hospital" means a general acute care hospital.

(2) "Nonparticipating mental health provider" means a psychiatrist, licensed psychologist, licensed marriage and family therapist, or licensed social worker who does not contract with the specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(3) "Provider group" means a medical group, independent practice association, or any other similar organization.

SEC. 6. Section 1373.96 of the Health and Safety Code is repealed.

~~SEC. 5. Article 12 (commencing with Section 1399.820) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:~~

~~Article 12. Continuity of Care~~

~~1399.820. The following definitions apply for the purposes of this article:~~

~~(a) "Evergreen contract" means a contract for services between a health care service plan and a provider that renews automatically unless terminated by either party pursuant to the contract's terms.~~

~~(b) "Nonparticipating mental health provider" means a psychiatrist, licensed psychologist, licensed marriage and family therapist, or licensed social worker who does not contract with the health care service plan.~~

~~(c) "Provider" means any of the following that contracts with a health care service plan: an individual physician and surgeon or osteopath, a medical group, an independent practice association or a similar organization, or a general acute care hospital.~~

~~1399.821. (a) A health care service plan shall fill a written continuity of care policy with the department before March 31, 2004.~~

~~(b) The health care service plan shall include all of the following in its written continuity of care policy:~~

~~(1) A description of the plan's process for the block transfer of enrollees from a terminated provider to a new provider.~~

~~(2) A description of the manner in which the plan facilitates the transition of care, completion of care, and maintenance of care for enrollees assigned to a new provider and for its new enrollees.~~

~~(3) A template of the notice the plan proposes to send to enrollees describing its policy and informing enrollees of their right to continuity of care.~~

~~(c) If approved by the department, the provisions of the written continuity of care policy shall become effective on July 1, 2004, and shall replace all prior continuity of care policies. The plan shall file a revision of the policy with the department if it makes a material change to it.~~

~~1399.822. (a) At least 75 days prior to the termination date of its contract with a provider, the health care service plan shall submit an enrollee block transfer filing to the department that includes the written notice the plan proposes to send to affected enrollees. The plan may not send this notice to enrollees until the department has reviewed and approved its content.~~

~~(b) Sixty days prior to the termination date of a contract between a health care service plan and a provider, the plan shall send the written notice by first-class United States' mail to enrollees who are assigned to the terminated provider. A plan that is unable to comply with this timeframe because of exigent circumstances shall apply to the department for a waiver. The plan is excused from complying with this requirement only if its waiver application is granted by the department. If the terminated provider is a hospital, the plan shall send the written notice to each enrollee who resides within a 15-mile radius of the hospital.~~

~~(c) The health care service plan shall send enrollees of a preferred provider organization the written notice required by subdivision (b) only if the terminated provider is a general acute care hospital.~~

~~(d) If a physician and surgeon or an osteopath terminates his or her relationship with a medical group, independent practice association, or similar organization that contracts with a health care service plan, the plan may require that group, association, or organization to send the notice required by subdivision (b).~~

~~(e) If, after sending the notice required by subdivision (b), a health care service plan reaches an agreement with a terminated provider to renew or enter into a new contract or to not terminate their contract, the plan shall offer each affected enrollee the option~~

~~to return to that provider. If an affected enrollee does not exercise that option, the plan may reassign the enrollee to another provider, consistent with the provisions of this article.~~

~~(f) This section shall become operative on July 1, 2004.~~

~~1399.823. A health care service plan and a provider shall include in all written or electronic communications sent to an enrollee, including, but not limited to, contract termination, block transfer, transition of care, completion of care, or maintenance of care, the following statement in not less than eight-point type: ''You may have a right to keep your provider under certain circumstances. Please contact your HMO's customer service department, and if you have further questions, you may contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, of at a TDD number for the hearing impaired at 1-877-688-9891, or at www.hmohelp.com.''~~

~~1399.824. (a) Continuity of care shall include the processes of transition of care, completion of care, and maintenance of care. All health care service plans shall provide transition of care to all enrollees. A health care service plan shall offer all of its enrollees who meet the criteria of Section 1399.826 the option to elect completion of care. A health care service plan shall offer all of its enrollees the option to elect maintenance of care as described in Section 1399.827.~~

~~(b) This section shall become operative on July 1, 2004.~~

~~1399.825. (a) Transition of care is the process of assigning an enrollee to a new provider when any of the following occurs:~~

~~(1) The contract between a health care service plan and a provider is terminated.~~

~~(2) An enrollee changes coverage from one health care service plan to another.~~

~~(3) The termination of an evergreen contract.~~

~~(4) The provider ceases operations within a specified service area.~~

~~(5) The closure or insolvency of a provider that contracts with the health care service plan.~~

~~(6) The termination of a contract between the health care service plan and provider for breach or cause, including fraud.~~

~~(7) Other circumstances as determined by the director.~~

~~(b) Transition of care shall include all of the following:~~

~~(1) The right of an enrollee to select a new provider.~~

~~(2) If the enrollee does not select a new provider, the assignment of a provider who is ready, willing, and able to provide services to the enrollee.~~

~~(3) The option for an enrollee to elect completion of care, as described in Section 1399.826.~~

~~(4) The option for an enrollee to elect maintenance of care, as described in Section 1399.827.~~

~~(c) The health care service plan shall begin the transition of care on the mailing date of the written notice required by Section 1399.822 or, for a new enrollee, upon the effective date of enrollment.~~

~~(d) The health care service plan may require a nonparticipating mental health provider to enter into the standard mental health provider contract. The plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortuous or wrongful acts arising out of the provision of services by the existing provider or nonparticipating mental health provider.~~

~~(e) This section shall become operative on July 1, 2004.~~

~~1399.826. (a) Completion of care is the process of an enrollee, who is in transition of care, continuing with his or her terminated provider under any of the following conditions:~~

~~(1) The duration of an acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.~~

~~(2) A serious chronic condition for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the terminated provider and consistent with good professional practice. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Continuation of care with a terminated provider under this paragraph shall not exceed 12 months from the contract termination date.~~

~~(3) The duration of a pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period.~~

~~(4) The duration of a terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.~~

~~(b) A health care service plan is not required to provide completion of care to an enrollee of an individual health care service plan contract for the termination of a contract between any health care service plan and a provider that occurred prior to the effective date of coverage for the enrollee under the individual health care service plan contract.~~

~~(c) This section shall become operative on July 1, 2004.~~

~~1399.827. (a) Maintenance of care is the process of an enrollee, who is in transition of care, continuing with his or her terminated provider until the enrollee has had an opportunity to select a different health care service plan and the coverage under that plan has become effective. Maintenance of care under this subdivision shall not exceed a period of 12 months commencing on the termination date of the contract between the plan and provider.~~

~~(b) The health care service plan shall allow an enrollee who has not selected a different health care service plan to select a new provider with which it contracts. If the enrollee does not select a new provider, the plan shall assign a provider who is ready, willing, and able to provide services to the enrollee.~~

~~(c) A health care service plan is not required to provide maintenance of care to an enrollee of an individual health care service plan contract for the termination of a contract between any health care service plan and a provider that occurred prior to the effective date of coverage for the enrollee under the individual health care service plan contract.~~

~~(d) This section shall become operative on July 1, 2004.~~

~~1399.828. (a) The parties shall establish the reimbursement rates for completion of care and maintenance of care before entering into a contract and before renewing a contract between them.~~

~~(b) If the contract between the health care service plan and a provider who is a medical group, independent practice association, or other similar organization is terminated for insolvency, closure, breach, or commission of a crime or fraud, the health care service plan is not required to provide completion of care or maintenance of care through the terminated provider.~~

~~(c) The health care service plan may require a nonparticipating mental health provider whose services are continued during completion of care or maintenance of care to agree in writing to the same terms and conditions in the plan's contract with participating mental health providers, including location within the plan's service area, reimbursement methodologies, and rates of payment.~~

~~(d) The provisions of this section shall apply to all contracts between a health care service plan and a provider that are entered into, amended, or renewed on or after July 1, 2004.~~

~~1399.829. (a) A violation of any provision of this article is subject to any and all enforcement remedies available to the director.~~

~~(b) Every health care service plan subject to this article shall report in writing to the department any violation of the provisions of this article by a provider within 10 days of its commission.~~

~~(c) The department shall post all violations reported under this article on its Internet Web site.~~

~~SEC. 6. Section 10133.561 is added to the Insurance Code, to read:~~

~~10133.561. A health insurer that provides services at alternative rates of payment, as described in Section 10133, shall send the written notice as required by subdivision (b) of Section 1399.822 of the Health and Safety Code only if the terminated contract is between the insurer and a general acute care hospital.~~

~~SEC. 7. Sections 2 to 4, inclusive, of this act shall become operative on July 1, 2004.~~

~~SEC. 8.~~

SEC. 7. Section 1373.96 is added to the Health and Safety Code, to read:

1373.96. (a) A health care service plan shall at the request of an enrollee, provide the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.

(b) (1) The completion of covered services shall be provided by a terminated provider to an enrollee who at the time of the contract's termination, was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services

from that provider for one of the conditions described in subdivision (c).

(c) The health care service plan shall provide for the completion of covered services for the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness.

(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(6) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to

occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

(d) (1) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

(2) Unless otherwise agreed by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(e) (1) The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

(2) Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting

providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f) The amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g) If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h) This section shall not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

(i) This section shall not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. This section shall not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition described in subdivision (c).

(j) The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude a plan from providing continuity of care beyond the requirements of this section.

(k) The following definitions apply for the purposes of this section:

(1) "Individual provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) "Nonparticipating provider" means a provider who is not contracted with a health care service plan.

(3) "Provider" shall have the same meaning as set forth in subdivision (i) of Section 1345.

(4) "Provider group" means a medical group, independent practice association, or any other similar organization.

SEC. 8. Section 10133.56 of the Insurance Code is amended to read:

10133.56. (a) ~~Disability insurers who provide hospital, medical, or surgical coverage and that negotiate and enter into contracts with professional or institutional providers to provide services at alternative rates of payment pursuant to Section 10133, shall, at the request of an insured, arrange for the continuation of covered services rendered by a terminated provider to an insured who is undergoing a course of treatment from a terminated provider for an acute condition, serious chronic condition, or a pregnancy covered by subdivision (b), at the time of the contract termination, subject to the provisions of this section.~~

~~(b) Subject to subdivisions (c) and (d), the insurer shall, at the request of an insured, provide for continuity of care for the insured by a terminated provider who has been providing care for an acute condition or a serious chronic condition, for a high-risk pregnancy, or for a pregnancy that has reached the second or third trimester. Continuity of care for an acute or serious chronic condition shall be provided for up to 90 days or a longer period if necessary to ensure a safe transfer to another provider, as determined by the insurer, in consultation with the terminated provider, consistent with good professional practice. In the case of pregnancy, continuity of care shall be provided through the course of the pregnancy and during the postpartum period. After the required period of continuity of care has expired pursuant to this section, coverage shall be provided pursuant to the general terms and conditions of the insured's policy.~~

~~(c)~~ *A health insurer that enters into a contract with a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 10133 shall, at the request of an insured, arrange for the completion of covered services by a terminated provider, if the insured is undergoing a course of treatment for any of the following conditions:*

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health insurer in consultation with the insured and the terminated provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.

(3) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness.

(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.

(6) Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

(b) The insurer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section, to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual

terms and conditions, ~~there shall be no obligation on the part of~~ the insurer *is not required* to continue the provider's services beyond the contract termination date. ~~Further, if the terminated provider or provider group voluntarily cancels the contract with the insurer, there shall be no obligation on the part of the provider or the insurer to continue the provider's services beyond the contract termination date.~~

~~(d)~~

(c) Unless otherwise agreed upon between the terminated provider and the insurer or between the terminated provider and the provider group, the agreement shall be construed to require a rate and method of payment to the terminated provider, for the services rendered pursuant to this section, that is the same as the rates and method of payment for the same services while under contract with the insurer and at the time of termination. The provider shall accept the reimbursement as payment in full, and shall not bill the insured for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision ~~(f)~~ *(e)*. ~~The insurer or provider group shall not be obligated to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this section.~~

~~(e)~~

(d) Notice as to how an insured may request ~~continuity~~ *completion* of ~~care~~ *covered services* pursuant to this section shall be provided in any insurer evidence of coverage and disclosure form issued after ~~July 1, 1999~~ *March 31, 2004*. An insurer shall provide a written copy of this information to its contracting providers and provider groups. An insurer shall also provide a copy to its insureds upon request.

~~(f)~~

(e) The payment of copayments, deductibles, or other cost sharing components by the insured during the period of ~~continuation~~ *completion* of ~~care~~ *covered services* with a terminated provider shall be the same copayments, deductibles, or other cost sharing components that would be paid by the insured when receiving care from a provider currently contracting with the insurer.

~~(g)~~

(f) If an insurer delegates the responsibility of complying with this section to its contracting entities, the insurer shall ensure that the requirements of this section are met.

~~(h)~~

(g) For the purposes of this section:

(1) ''Provider'' means a person who is a licentiate as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) ''Terminated provider'' means a provider whose contract to provide services to insureds is terminated or not renewed by the insurer or one of the insurer's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the insurer or contracting provider group.

(3) ''Provider group'' includes a medical group, independent practice association, or any other similar ~~group of providers~~ *organization*.

~~(4) ''Acute condition'' means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention, and has a limited duration.~~

~~(5) ''Serious chronic condition'' means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:~~

~~(A) Persists without full cure or worsens over an extended period of time.~~

~~(B) Requires ongoing treatment to maintain remission or prevent deterioration.~~

~~(i)~~

(h) This section shall not require an insurer or provider group to provide for ~~continuity of care~~ *the completion of covered services* by a provider whose contract with the insurer or *provider* group has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(j) This section shall not require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the insurer contract.

(k) The provisions contained in this section are in addition to any other responsibilities of insurers to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude an insurer from providing continuity of care *beyond the requirements of this section.*

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SEC. 9.~~

SEC. 10. This act shall become operative only if Senate Bill 244 of the 2003–04 Regular Session is enacted and becomes effective on or before January 1, 2004.

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